IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
SOUTHERN DIVISION

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, *et al.*, Plaintiffs-Counterdefendants, - against - ADVANCED SURGERY CENTER OF BETHESDA, LLC, *et al.*, Defendants-Counterclaimants.	CASE NO. 14-CV-02376 DKC Judge Deborah K. Chasanow ECF Case Oral Argument Requested

MEMORANDUM OF LAW IN SUPPORT OF CIGNA'S MOTION TO DISMISS THE ASCS' COUNTERCLAIMS

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INTRODUCTION

Call it "fee forgiving" or "price matching," the crux of this action is the counterclaiming ASCs'[1] undisputed practice of luring potential patients to their out-of-network facilities by waiving the patients' required out-of-network co-insurance and deductible payments. Specifically, the ASCs charge their patients reduced amounts that supposedly approximate what the patients would have paid if they visited facilities within Cigna's provider network, but the ASCs still bill Cigna their undiscounted rates. As a result, the ASCs have unlawfully collected millions of dollars in plan benefits that should have never been paid pursuant to the terms of Cigna's health plans.

Given this background, it is not surprising that the ASCs have failed to state any viable counterclaims against Cigna. All of the ASCs' ERISA claims (Counts I through III) should be dismissed because the ASCs sue as their patients' assignees without pleading the actual assignment language that would give them the right to do so. Such allegations are necessary to show the Court that the ASCs have received the type of valid and specific assignment that the Fourth Circuit requires for derivative ERISA claims. Indeed, the ASCs do not even suggest that they received assignments that would allow them to raise their ERISA claims for breach of fiduciary duty and failure to provide plan information.

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[1] For the purposes of this Memorandum of Law, "ASCs" refers to the collective of Defendants-Counterclaimants Advanced Surgery Center of Bethesda, LLC, Bethesda Chevy Chase Surgery Center, LLC, Deer Pointe Surgical Center, LLC, Hagerstown Surgery Center, LLC, Leonardtown Surgery Center, LLC, Maple Lawn Surgery Center, LLC, Maryland Specialty Surgery Center, LLC, Monocacy Surgery Center, LLC, Piccard Surgery Center, LLC, Riva Road Surgical Center, LLC, SurgCenter at National Harbor, LLC d/b/a Harborside Surgery Center, SurgCenter of Glen Burnie, LLC, SurgCenter of Greenbelt, LLC, SurgCenter of Silver Spring, LLC, SurgCenter of Southern Maryland, LLC, SurgCenter of Western Maryland, LLC, SurgCenter of White Marsh, LLC, Timonium Surgery Center, LLC, Upper Bay Surgery Center, LLC, and Windsor Mill Surgery Center, LLC.

"Cigna" refers to the collective of Connecticut General Life Insurance Co. and Cigna Health and Life Insurance Co.

The ASCs' claim for breach of fiduciary duty under ERISA § 502(a)(3) (Count II) also fails because it merely repackages a benefits claim under ERISA § 502(a)(1)(B). Indeed, even in this lawsuit the ASCs' 502(a)(3) and 502(a)(1)(B) claims rely on an identical theory of liability and seek the same relief, just the type of duplicative pleading prohibited in this Circuit. Moreover, the proper focus of a breach of fiduciary duty claim is a challenge to the interpretation of the ERISA statute itself, but the ASCs' 502(a)(3) claim challenges only Cigna's interpretation of ERISA plans, reinforcing that Count II is really a benefits claim.

The ASCs' ERISA claim for failure to provide information (Count III) likewise fails as a matter of law. ERISA requires only that Cigna provide the specific basis for its denials, and the ASCs' own counterclaim leaves no doubt that Cigna has met its disclosure obligations.

The ASCs' state-law claims (Counts IV through VI) fare no better. As with their ERISA claims, the ASCs' breach of contract claim (Count IV) fails because the ASCs do not plead that they received specific assignments to sue under their patients' non-ERISA plans.

The ASCs' claim for unjust enrichment (Count V) is preempted by ERISA to the extent that it concerns services for patients covered by ERISA plans, as determining liability for these claims would require the Court to interpret the terms of these patients' ERISA plans. Moreover, the ASCs do not allege that Cigna received any benefit at the ASCs' expense or that Cigna even knew that the ASCs provided services to Cigna's plan members before the ASCs submitted their bills, both necessary elements for this cause of action.

Finally, to state a claim for promissory estoppel, the ASCs must show that their only remedy for allegedly wrongful denials of coverage is to force Cigna to overturn its coverage decisions, but the ASCs' own counterclaim shows that this is not the case, as they allege that they have the right to seek full reimbursement from their patients if Cigna does not cover their claims. The ASCs' patients could also directly petition Cigna to overturn its coverage denials, which means the ASCs would not suffer an injustice if the ASCs could not independently enforce Cigna's alleged coverage promises. Indeed, the patients' plans specifically provide for this type of relief, and the ASCs' attempt to skirt this well-defined process has no merit.

BACKGROUND

To help manage health care costs, Cigna-administered health plans incentivize members to use Cigna's network of healthcare providers, who have agreed to accept discounted rates for their services in exchange for receiving access to Cigna's customers. (D.E. 42, Defendants'/Counter Plaintiffs' Counterclaim ("CC") ¶ 30.) Accordingly, Cigna-administered plans generally provide that members will be responsible for lower co-insurance and deductible payments if they see network providers rather than out-of-network providers. (CC ¶¶ 35, 39.) The higher cost-sharing payments required for out-of-network services encourage the use of less costly in-network providers, and also serve as a check on the ability of out-of-network providers to charge astronomical rates for their services because when patients are required to pay a percentage of their out-of-network providers' charges as co-insurance, they generally avoid seeking treatment at out-of-network providers with inflated rates. *See, e.g.*, *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991) (noting that an insurance plan's "combination of less use and lower charges (together with the 20% reduction in insured payments in the event care is furnished) makes medical insurance less expensive and enables employers to furnish broader coverage").

At issue in the ASCs' counterclaim is their billing practice that tries to skirt these fundamental cost controls. Specifically, the ASCs admit that they lure patients to their facilities by waiving the patients' required out-of-network cost-sharing responsibilities, instead charging them "in-network cost contribution requirements (i.e., the patients' in-network co-payments, deductibles, and co-insurance)." (CC ¶ 36.) At the same time, the ASCs bill Cigna at their unreduced "normal" out-of-network rates, which are higher than the in-network rates on which they based the member responsibility of Cigna's customers. (*Id.* ¶ 30 (admitting that in-network providers agree to "***discounted*** rates") (emphasis added).) While the ASCs refer to this practice as their "price matching policy," the healthcare industry more commonly calls it—and any other practice in which a provider submits charges to a member's plan but waives collection of all or some of the member's cost-sharing responsibility—"cost share waiver" or "fee-forgiving."[2]

Not surprisingly, court after court has recognized the legitimate interests in preventing fee-forgiving schemes.[3] For example, in *Kennedy*, the Seventh Circuit examined a Cigna plan that required the member to pay 20% co-insurance and provided that "[n]o payment will be made for expenses incurred . . . for charges which the Employee or Dependent is not legally required to pay." 924 F.2d at 701. The provider plaintiff waived the member's co-insurance payment but billed Cigna for his full charges; as a result, the Seventh Circuit found that the provider misstated

[2] While the ASCs insist that their patients "remain responsible for the full amount of the charges if CIGNA does not pay their claims," they allege no instance in which they actually attempted to collect from their patients. (CC ¶ 40.) In fact, they cannot, as the record will show that the ASCs affirmatively tell their patients that the patients "would not have to pay [their] bills." (Compl. ¶ 122.) Moreover, given that the ASCs premise their business model on attracting patients by promising out-of-network services at reduced in-network rates (CC ¶ 36), it is implausible that they ever intended to collect the full amount of their bills from Cigna's members. Indeed, the Seventh Circuit has already rejected the viability of this argument. *See Kennedy*, 924 F.2d at 701-02 (finding that provider could not require member to pay his coinsurance amount only if the plan failed to pay its portion of the provider's charges, because this creates a "delicious circularity," and the court "could not break the circle in favor of reimbursement without abrogating the [plan's] co-payment requirement—a requirement that [the plan] had every legal entitlement to create").

[3] *See Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc.*, 522 F. App'x 81, 82 (2d Cir. 2013) (where provider "routinely" waived patients' "deductible and coinsurance obligations," it was appropriate for insurer to reduce payment); *Smilecare Dental Grp. v. Delta Dental Plan of Calif.,* 88 F.3d 780, 786 (9th Cir. 1996) (affirming dismissal of Sherman Act claim and noting that "[plan]'s policy is supported as a matter of law by a legitimate business justification–its interest in protecting the disciplinary effect of its co-payment plan"); *Davidowitz v. Delta Dental Plan of Calif., Inc.*, 946 F.2d 1476, 1479 (9th Cir. 1991) (cost-sharing "waivers annul the benefits of the co-payment system"); *N. Cypress Med. Ctr. Operating Co. v. CIGNA Healthcare*, 09-cv-2556, slip op. at 13 (S.D. Tex. Aug. 10, 2012) (Cigna's plans do not cover amounts charged by fee-forgiving providers because "any alternative reading would result in significant and unanticipated costs to the ERISA plans").

his actual charges. *Id*. The court thus affirmed Cigna's right to deny payment for the provider's charges, explaining that the "[patient]'s plan and CIGNA's policy require co-payments in order to maintain incentives that hold down the cost of medical care," and "its terms will be enforced." *Id*. at 702.

The ASCs try to excuse their fee forgiving by arguing that they want to make their charges "affordable" to Cigna's customers. (CC ¶ 37.) The clear implication is that their out-of-network rates—that is, the undiscounted amounts the ASCs argue Cigna should pay—are not affordable. As opinions like *Kennedy* make clear, such practices have a perverse effect on healthcare insurance, ultimately making coverage more expensive for everyone by increasing the amounts plans pay to providers, and in turn increasing premiums.

The ASCs initiated state court litigation in July 2014 by filing more than one hundred nearly identical small claims complaints in the District Court of Maryland, in multiple counties. On July 25, 2014, Cigna filed the Complaint in this case, alleging, among other things, ERISA, conspiracy, and fraud claims against the ASCs and their related entity, Surgical Center Development, Inc. d/b/a SurgCenter Development. (D.E. 1.) Over the course of August 2014, Cigna removed fifty-three of the small claims complaints to this Court on the grounds that the ASCs' claims were preempted by ERISA. This Court granted consolidation of the removed small claims complaints with the instant case on September 2, 2014. (D.E. 40.) The ASCs filed their Counterclaims on October 21, 2014. Cigna now moves to dismiss the ASCs' Counterclaim for failure to state a claim under Rule 12(b)(6).

ARGUMENT

I. THE ASCS FAIL TO STATE VIABLE ERISA CLAIMS (COUNTS I THROUGH III).

A. The ASCs Have Not Pled They Have Standing To Bring Any ERISA Claims.

The ASCs do not dispute that they lack standing to sue under ERISA on their own behalves because ERISA § 502(a) permits claims by only "participant[s], beneficiar[ies], or fiduciar[ies]." 29 U.S.C. § 1132(a); *see also HealthSouth Rehab. Hosp. v. Am. Nat. Red Cross*, 101 F.3d 1005, 1008 (4th Cir. 1996) ("a person who is neither a participant nor a beneficiary lacks standing to bring an ERISA action against a fiduciary or plan administrator"). Instead, the ASCs purport to assert ERISA claims as assignees of their patients. (CC ¶ 4 ("The ASCs bring this action pursuant to [ERISA] as assignees . . ."); *see also id.* ¶¶ 35, 83, 92, 98, 100.)

But not just any assignment will do. To have standing to sue under ERISA, a provider must receive a "***valid***" and "***specific*** assignment of rights by a participant or beneficiary." *Peninsula Reg'l Med. Ctr. v. Mid Atl. Med. Servs., LLC.*, 327 F. Supp. 2d 572, 576 (D. Md. 2004) (emphasis added); *Brown v. Sikora & Assocs.*, Inc., 311 F. App'x 568, 570 (4th Cir. 2008) (noting that derivative standing under ERISA can exist "when based on the ***valid*** assignment of ERISA health and welfare benefits") (emphasis added); *Chesters v. Welles-Snowden*, 444 F. Supp. 2d 342, 346 n.1 (D. Md. 2006) (noting that plaintiff "would not have standing under ERISA because she cannot claim any legal entitlement to the benefits" if "there was no valid assignment of benefits").[4]

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[4] *See also Harris Methodist Fort Worth v. Sales Support Servs. Inc. Employee Health Care Plan*, 426 F.3d 330, 334 (5th Cir. 2005) (to bring ERISA claim as an assignee, provider must show that it obtained "valid" and "full" assignment of benefits); *Franco v. Conn. Gen. Life Ins. Co.*, 818 F. Supp. 2d 792, 811 (D.N.J. 2011) (An assignment "limited to direct receipt of the ONET [out-of-network] reimbursement and/or is qualified by the provider's reservation of his or her right to collect the entire charge for the service from the patient . . . in no way can be construed as tantamount to assigning the right [to] enforce his or her rights under the plan."); *N. Jersey Ctr. for Surgery, P.A. v. Horizon Blue Cross Blue Shield of N.J., Inc.*, Civ. No. 07-4812, 2008 WL

Moreover, not all ERISA assignments convey the same rights. "Like any other contract, the scope of the assignment depends foremost upon the language of the agreement itself." *Via Christi Reg'l Med. Ctr., Inc. v. Blue Cross & Blue Shield of Kan.*, No. 04-1253, 2006 WL 3469544, at *7 (D. Kan. Nov. 30, 2006). For instance, an assignment may give the right to bring only a claim for benefits, but not a claim for breach of fiduciary duty. *See Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1292 (9th Cir. 2014) (because assignee provider that was "assigned only the right to bring claims for payments of benefits, [provider] has no right to bring claims for breach of fiduciary duty"); *Sanctuary Surgical Ctr., Inc. v. Aetna Inc.*, 546 F. App'x 846, 852 (11th Cir. 2013) (providers' assignment agreements with patients authorizing insurance benefits to be paid directly to provider assigned only the right to receive benefits, not the right to assert claims for breach of fiduciary duty or civil penalties). Or it might not be an assignment at all and instead confer only the ***authorization*** to collect payment and file appeals rather than the transfer of the right to sue under ERISA. *Spinedex*, 770 F.3d at 1297 ("[T]here is no evidence that United was aware . . . that Spinedex was acting as its patients' assignee. So far as United knew, Spinedex was acting merely as an authorized representative charged with filing, collecting, or appealing a claim on behalf of the patient."). For the ASCs "to sufficiently plead its standing as an ERISA beneficiary," the ASCs must therefore "provide the language of the actual assignments." *Sanctuary Surgical Ctr., Inc. v. UnitedHealthcare, Inc.*, Civ. No. 10-81589, 2011 WL 6935289, at *4 (S.D. Fla. Dec. 30, 2011).

The ASCs have not met this standard. While the ASCs plead in conclusory fashion that they have received an assignment of "the patient's rights and benefits under the Cigna health insurance plan" (CC ¶ 35), they have not pled the specific language that allegedly gives them

4371754, at *4, *8 (D.N.J. Sept. 18, 2008) (A "valid" assignment requires a "complete" and "unequivocal" assignment of rights.).

standing to sue under ERISA. Without such specificity, this Court cannot assess what rights the ASCs were actually assigned, if any, and all three of their ERISA claims fail as a matter of law. *See Sanctuary Surgical*, 2011 WL 6935289, at *4 (finding that without the specific language of the plaintiff's alleged assignment, the court could not "determine whether, as a matter of law, the alleged assignments actually conferred upon [the ASCs] standing to assert").

Indeed, the ASCs make no assertion whatsoever that their patients transferred their rights to bring claims for breaches of fiduciary duty or failure to provide information. This omission is fatal to their ability to raise such claims under ERISA §§ 502(a)(3) and 502(c)(1). *See Spinedex*, 770 F.3d at 1292; *Sanctuary Surgical*, 546 F. App'x at 852; *Tex. Life, Acc. Health & Hosp. Serv. Ins. Guar. Ass'n v. Gaylord Ent't Co.*, 105 F.3d 210, 218-19 (5th Cir. 1997) (holding that association did not have derivative standing to bring a claim for breach of fiduciary duty because there was no evidence that such right had been "expressly and knowingly assigned"). At a minimum, therefore, Counts II and III should be dismissed.

B. The ASCs Cannot Pursue Their Claims Under ERISA § 502(a)(3) (Count II) Because They Seek the Same Relief Under ERISA § 502(a)(1)(B).

Even if the ASCs had pled that they had standing to bring their ERISA claims, their claim under ERISA § 502(a)(3) fails for the additional reason that it merely "repackage[s]" their claim for benefits under ERISA § 502(a)(1)(B). *See Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996). As the Fourth Circuit has explained, "[i]ndividualized equitable relief under § 1132(a)(3) is normally appropriate only for injuries that do not find adequate redress in ERISA's other provisions." *Korotynska v. Metro. Life Ins. Co.*, 474 F.3d 101, 102, 107 (4th Cir. 2006) (citing *Varity*, 516 U.S. at 515; affirming a dismissal judgment on the pleadings because "§ 1132(a)(1)(B) affords the plaintiff adequate relief for her benefits claim, and a cause of action under § 1132(a)(3) is thus not appropriate").

Courts in this Circuit accordingly regularly dismiss a plaintiff's breach of fiduciary duty claim where it is duplicative of a claim for benefits under section 502(a)(1)(B). *See, e.g.*, *Leach v. Aetna Life Ins. Co.*, No. CIV.A. WMN-13-2757, 2014 WL 470064, at *5 (D. Md. Feb. 5, 2014) (dismissing 502(a)(3) claim where "[p]laintiff has not stated a claim under § 502(a)(3) that is distinct from her claim under § 502(a)(1)(B)"); *Wozniak v. S.T.A. of Baltimore--I.L.A. Container Royalty Fund*, Civ. A. No. GLR-12-1540, 2012 WL 5388845, at *4 (D. Md. Oct. 31, 2012) ("Here, Mr. Wozniak has no breach of fiduciary duty cause of action because he seeks individual plan benefits that are redressable elsewhere in ERISA's scheme."); *Blair v. Nat'l City Mortg. Corp. Welfare Benefits Plan*, No. 8:09-CV-00906-AW, 2011 WL 3885484, at *2 (D. Md. Sept. 2, 2011) (a "[p]laintiff's claim for equitable relief under section 502(a)(3) is improper because section 502(a)(1)(B) is the appropriate vehicle"); *Pearson v. Abbott Labs. Annuity Retirement Plan*, Civ. A. No. 4:06-cv-03330-RBH, 2007 WL 2688616, at *3 (D.S.C. Sept. 10. 2007) (collecting cases dismissing improper 502(a)(3) claims).

The ASCs' 502(a)(3) claim falls squarely within this impermissible category of improperly repackaged 502(a)(1)(B) claims. The ASCs make no attempt to disguise that their 502(a)(3) claim challenges Cigna's decision to "reduc[e] or deny[] benefits payable to the ASCs . . . based on [Cigna's alleged] misconstruction and/or misapplication of [a plan] exclusion." (CC ¶ 87.) Moreover, their requested relief is an amount equal to the value of the services that Cigna allegedly "wrongfully withheld." (CC ¶ 92.)

This is clearly a claim for benefits. In fact, the ASCs' benefits claim under section 502(a)(1)(B) alleges the same underlying conduct and requests the same type of relief. (*Compare* CC ¶ 81 ("Cigna has breached the terms of its plans by arbitrarily denying or reducing payments due to the ASCs"), *with id.* ¶ 87 ("Cigna violated this duty by reducing or denying benefits" and citing same plan language regarding exclusions as ¶ 81); *compare* CC ¶ 82-83 (seeking "unpaid benefits" and "a declaration from this Court clarifying their patients' rights to future benefits") *with id.* ¶ 92 (seeking repayment of "amounts wrongfully withheld").)[5]

The ASCs' 502(a)(3) claim fails for another reason. Under Fourth Circuit precedent, "[a] claim for fiduciary duty is actually a claim for benefits where the resolution of the claim rests upon an interpretation and application of an *ERISA-regulated plan* rather than upon an interpretation and application of *ERISA*." *Smith v. Snydor*, 184 F.3d 356, 362 (4th Cir. 1999) (emphasis in original). Here, the ASCs attack Cigna's alleged "misconstruction and/or misapplication of [a plan] exclusion." (CC ¶ 46.) That is precisely the type of interpretation and application of plan terms that should be brought under 502(a)(1)(B), not 502(a)(3). *See Pearson*, 2007 WL 2688616, at *3 (noting that plaintiff could not "simply re-characterize" his claim for "benefits due under the terms of the [plan]" as a breach of fiduciary claim under § 502(a)(3)).

C. The ASCs Have Not Pled a Claim for Non-Disclosure of Information Relating to Cigna's Decisions to Deny Payment (Count III).

The ASCs' attempt to supplement their core ERISA benefits claim with a claim under 502(c)(1)(B) (Count III) is also unavailing. Specifically, the ASCs contend that Cigna failed to disclose the "documents that Cigna claims provide the basis for its refusal to reimburse the ASCs for services the ASCs have rendered." (CC ¶ 96.)

The ASCs do not specify what in the ERISA statute requires such disclosure. The closest that ERISA comes is § 503, which simply states that, when a plan denies benefits, it must "[set]

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5 The ASCs' unexplained general request for "injunctive and declaratory relief" under § 502(a)(3) does not change this conclusion, as their prayer for relief make clear that they are still seeking only relief related to the calculation and interpretation of plan benefits. *See J.J. Crewe & Son, Inc. Profit Sharing Plan v. Talbot*, No. CIV.A. ELH-11-2871, 2012 WL 1994778, at *4 (D. Md. June 1, 2012) (noting that a request for "declaratory and injunctive relief" requiring a defendant to pay a monetary amount pursuant to an ERISA plan is not "equitable relief" cognizable under 502(a)(3)) (citing *Great–West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 208 (2002)).

forth the specific reasons for such denial." 29 U.S.C. § 1133. As the Fourth Circuit has noted, this provision requires an administrator only to "supply the claimant with a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Larson v. Old Dominion Freight Line, Inc.*, 277 F. App'x 318, 321 (4th Cir. 2008) (quotations and citations omitted).

Here, the ASCs admit that Cigna informed them it reduced or denied benefits because the ASCs' patients' plans excluded "charges for which [the patients] are not obligated to pay or for which [the patients] are not billed or for which [the patients] would not have billed except that they were covered under the plan," and the ASCs "did not obligate the patient to pay or did not bill the patient." (*See, e.g.,* CC at ¶¶ 3, 44, 87.) Indeed, the exhibits that the ASCs attached to the complaints for their removed small claims actions show just that. (*See, e.g.*, Compl., Ex. 1, *Leonardtown Surgery Ctr., LLC v. Cigna Health & Life Ins. Co.*, *et al.*, No. 8:14-CV-2497-DKC (D. Md. Aug. 6, 2014), ECF No. 2 (letter noting where exclusion language appears in patient's plan and stating that "Cigna has developed information that [the ASC] has engaged in a practice by which the [ASC] did not obligate its patients to pay their full cost share obligation . . . or did not bill its patients for the same").)

The ASCs' own pleadings thus show that Cigna has met its disclosure obligations under ERISA. *See Larson*, 277 F. App'x at 321 (defendant's letters terminating benefits sufficient under ERISA § 503); *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 127 (4th Cir. 1994) (no ERISA § 503 violation despite plaintiff's argument that defendant failed "to provide specific reasons" for denial of benefits because "[w]hile [defendant's] notice of denial could have been more thorough, it substantially complied with the applicable ERISA regulations"); *see also Barden v. Sheet Metal Workers Local No. 20 Welfare & Benefit Fund*, 12

F. App'x 412, 414-15 (7th Cir. 2001) (letters explaining why "claims had been partially denied" sufficient to satisfy ERISA's requirement to supply plan participant of "a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review").

II. THE ASCS FAIL TO PLEAD ANY VIABLE STATE-LAW CLAIMS (COUNTS IV THROUGH VI).

In addition to their ERISA claims, the ASCs assert three state-law claims for breach of contract (Count IV), unjust enrichment (Count V), and promissory estoppel (Count VI). For the following reasons, none of these counts states a cause of action.

A. The ASCs' Breach of Contract Claim (Count IV) Fails Because the ASCs Do Not Adequately Plead Their Standing as Assignees.

As with the ASCs' claim for ERISA benefits, the ASCs are not parties to their patients' non-ERISA plans and therefore assert that they have a right to sue Cigna as assignees of those plans. (CC ¶ 31 (pleading that the ASCs "have not contracted with Cigna."); *id.* ¶ 100.) But here too ASCs fail to provide the actual language of any assignments; instead, they rely on the legal assertion that whatever language they obtained was sufficient to give them the right to their patients' benefits and ability to bring lawsuits. (*Id.* ¶¶ 35, 100.) That is not enough. *See Petals Factory Outlet of Del., Inc. v. EWH & Assocs.*, 90 Md. App. 312, 318-19, 600 A.2d 1170, 1174 (Md. Ct. Spec. App. 1992) (standing to sue as an assignee of contractual rights requires allegations specifying what "the assignor intended to assign"); *see also* Restatement (Second) of Contracts § 324 (1981) ("It is essential to an assignment of a right that the obligee manifest an intention to transfer the right to another person without further action or manifestation of intention by the obligee.").

B. The ASCs' Unjust Enrichment Claim (Count V) Fails.

1. The ASCs' Claim for Unjust Enrichment is Preempted by ERISA.

The ASCs' state-law claim for unjust enrichment is preempted by ERISA to the extent that it concerns patients covered by ERISA plans. "[W]hen the validity, interpretation or applicability of ***a plan term*** governs the participant's entitlement to a benefit or its amount, the claim for such a benefit falls within the scope of § 502(a)." *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 291 (4th Cir. 2003) (emphasis in original); *see also Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004) (finding complete preemption of state-law claims where defendants' liability for damages "would exist here only because of petitioners' administration of ERISA-regulated benefit plans"); *Guardian Life Ins. Co. of Am. v. Reinaman*, No. CIV. WDQ-10-1374, 2011 WL 2133703, at *7 (D. Md. May 26, 2011) ("[Plaintiff's] claims for breach of contract, fraud, promissory estoppel, negligence inducement, declaratory judgment, and quantum meruit are preempted [by ERISA] and will be dismissed.") (citing *Gresham v. Lumbermen's Mut. Cas. Co.*, 404 F.3d 253, 258 (4th Cir. 2005) ("Generally, when a state law claim may fairly be viewed as an alternative means of recovering benefits allegedly due under ERISA, there will be preemption.")).

Here, the ASCs' state-law claim of unjust enrichment challenges "Cigna's [alleged] misconstruction and/or misapplication of its plans' language." (CC ¶ 108.) Resolving this claim necessarily requires an interpretation of Cigna's plans; to the extent such plans are governed by ERISA, they are therefore preempted. *Singh*, 335 F.3d at 291 (finding unjust enrichment claim that sought reimbursement of monies paid to health insurance plan pursuant to subrogation term was preempted by ERISA); *see also Reinaman*, 2011 WL 2133703, at *7 (granting defendant's motion to dismiss state law quantum meruit claim because such claims were preempted under conflict preemption doctrine).

In their motion to dismiss Cigna's complaint, the ASCs argue that Cigna's state-law claims are also preempted. But for Cigna's state-law claims, the focal point is Defendants' fraudulent conduct, whereas the ASCs' claim for unjust enrichment depends on their allegation that Cigna misinterpreted the terms of their patients' plans. To find that Cigna's claims are preempted under such circumstances contradicts this Court's decision in *National Centers for Facial Paralysis, Inc. v. Wal-Mart Claims Administration Group Health Plan*, 247 F. Supp. 2d 755 (D. Md. 2003). To the extent, however, that the Court does not follow the holding in *National Centers* and finds Cigna's state-law claims preempted, the ASCs' claim for promissory estoppel should suffer the same fate.

Indeed, courts have specifically found promissory estoppel claims are preempted because allowing such claims to proceed would in essence allow a plaintiff to modify a plan's terms outside the regulatory scheme outlined through ERISA. *Gross v. St. Agnes Health Care, Inc.,* No. CIV.A. ELH-12-2990, 2013 WL 4925374, at *13 (D. Md. Sept. 12, 2013) (finding promissory estoppel was preempted where provider sought to enforce alleged promise of pre-service coverage determinations because a party may not modify the terms of patients' ERISA plans outside of the prescribed ERISA regulations) (citing *HealthSouth*, 101 F.3d at 1010); *see also Afram v. United Food & Commercial Workers Unions & Participating Employers Health & Welfare Fund*, 958 F. Supp. 2d 275, 279 (D.D.C. 2013) (provider's promissory estoppel and breach of contract claims preempted by ERISA); *Reinaman*, 2011 WL 2133703, at *7; *Termini v. Life Ins. Co. of N. Am.*, 464 F. Supp. 2d 508, 515 (E.D. Va. 2006) (plaintiffs' state-law promissory estoppel claim preempted by ERISA).

2. The ASCs' Claim for Unjust Enrichment Fails as a Matter of Law.

The ASCs' unjust enrichment claim also fails because the ASCs do not allege that they provided ***Cigna*** a benefit at the ASCs' expense. *MEE Direct LLC v. Tran Source Logistics, Inc.*, No. CIV. JKB-13-455, 2014 WL 585637, at *4 (D. Md. Feb. 14, 2014) (dismissing unjust enrichment claim where defendant "did not receive any benefit directly from [p]laintiffs"), *aff'd* --- Fed. App'x. ----, No. 14-1226, 2014 WL 4922456 (4th Cir. Oct. 2, 2014). Instead, the ASCs claim that Cigna received a benefit from its members in the form of premiums and that Cigna's members received a benefit from the ASCs in the form of medical services. (CC ¶¶ 109-12.) In other words, to the extent that Cigna was allegedly unjustly enriched by its receipt of plan premiums, it was at the expense of the members who paid such premiums, not the ASCs, and to the extent that the ASCs provided a benefit to anyone through their services, it was to Cigna's plan members, not Cigna. This precludes the ASCs' unjust enrichment claim. *See MEE Direct*, 2014 WL 585637, at *4.

The ASCs' allegation that Cigna received a benefit by keeping funds it owed to the ASCs for services provided to Cigna plan members does not save their claim for three reasons. First, the ASCs allege that the "Cigna-insured patients remain responsible for the full amount of the ASCs' charges if Cigna does not pay their claims." (CC ¶ 40.) The ASCs do not, however, allege that they tried to collect any payments from Cigna's plan members. Nor was this omission merely an oversight, because the ASCs affirmatively tell patients that the patients will not be responsible for any charges from the ASC. (Compl. ¶¶ 122-26.) Accordingly, the ASCs were underpaid for their services only because they failed to collect their bills from their patients, the parties who received the ASCs' services and were responsible for their payment.

Second, the ASCs do not allege that Cigna knew that plan members received services from the ASCs until after Cigna received the ASCs' bills. As the Maryland Supreme Court has explained, where a plaintiff's unjust enrichment claim is based on services rendered, the plaintiff must plead that the defendant knew of and accepted the benefit because otherwise a third party would be "encouraged to invade another's freedom of choice about his own affairs." *Hill v. Cross Country Settlements, LLC*, 402 Md. 281, 300 n.12, 936 A.2d 343, 354 n.12 (2007); *see also The Fischer Org., Inc. v. Landry's Seafood Restaurants, Inc.*, 143 Md. App. 65, 76-80, 792 A.2d 349, 356-57 (Md. Ct. Spec. App. 2002) (real estate brokerage firm who located replacement tenant for restaurant owner was not entitled to recovery commission under a theory of unjust enrichment because the owner had no knowledge of firm's negotiations with the replacement tenant).

Here, the ASCs do not allege that they informed Cigna before providing services to Cigna's members, giving Cigna no opportunity to decline the alleged benefit before the ASCs provided it to Cigna's members. A claim for unjust enrichment will not lie under such circumstances. *See Fischer*, 792 A.2d at 356-57; *cf., e.g.*, *Josephson v. United Healthcare Corp.*, No. 11-CV-3665, 2012 WL 4511365, at *5 (E.D.N.Y. Sept. 28, 2012) (dismissing out-of-network provider's unjust enrichment claim against health insurer under New York law for services that the doctor provided to members of insurer's benefits plans because the services were performed at the request of the members, not the insurer); *Pekler v. Health Ins. Plan of Greater N.Y.*, 888 N.Y.S.2d 196, 196 (N.Y. App. Div. 2009) (same); *Kirell v. Vytra Health Plans Long Is., Inc.*, 815 N.Y.S.2d 185, 185 (N.Y. App. Div. 2006) (same).

Third, Cigna could not keep any benefit from the ASCs by allegedly withholding funds for reimbursement because, absent an assignment, Cigna does not owe the ASCs any payments; instead, Cigna would have owed that money to the ASCs' patients. As noted in Section I.A. above, the ASCs did not plead valid assignments, but even if they had, their unjust enrichment claim would still fail. Maryland law precludes recovery under a theory of unjust enrichment where a valid contract covers the same subject matter. *County Comm'rs of Caroline County v. J.*

Roland Dashiell & Sons, Inc., 358 Md. 83, 95-96, 747 A.2d 600, 607 (2000). As assignees, the ASCs would then stand in the shoes of their patients, and their patients' benefit plans with Cigna clearly covers the subject matter of the ASCs' unjust enrichment claim is clearly covered by their patients' plans. In fact, the ASCs premise their claims for unjust enrichment, ERISA, and breach of contract on the same allegation that "Cigna has repeatedly reduced or denied payment to the ASCs for care provided to Cigna's insureds based on its misconstruction and/or misapplication ***of certain language in its plan documents***." (*Compare* CC ¶ 108 (emphasis added) *with id.* ¶¶ 81, 88, 101-02, 105.) To the extent that the ASCs wish to claim payments based on such allegations, the ASCs must therefore do so pursuant to the terms of their patients' contract, not under a quasi-contract theory. *See, e.g., FLF, Inc. v. World Pubs., Inc.*, 999 F. Supp. 640, 644 (D. Md. 1998) (dismissing claim for unjust enrichment where express contract existed between parties); *see also Am. Med. Ass'n v. United Healthcare Corp.*, No. 00 Civ. 2800, 2007 WL 683974, at *10 (S.D.N.Y. Mar. 5, 2007) (discussing cases under New York law and dismissing unjust enrichment claim against non-par provider for alleged over-reimbursement because its patients' plans determined reimbursement for medical services).

C. The ASCs Have Not Stated a Claim for Promissory Estoppel (Count VI).

Unlike their other claims, the ASCs' promissory estoppel claim is not based on Cigna's denial of benefits due to the ASCs' fee-forgiving policy. Rather, the ASCs allege that Cigna represented to the ASCs that their patients' plans covered certain unidentified services, and that the ASCs relied on Cigna's alleged pre-service representations to provide services to these patients, but ultimately Cigna did not cover the ASCs' claims.

The ASCs are missing a key element of promissory estoppel under Maryland law—that Cigna's actions "cause[d] detriment which can ***only*** be avoided by the enforcement of the promise." *See Citiroof Corp. v. Tech Contracting Co., Inc.*, 159 Md. App. 578, 589, 860 A.2d

425, 432 (Md. Ct. Spec. App. 2004) (emphasis added); *Wynn v. Hewlett-Packard Co.*, No. 8:11-CV-01287-AW, 2012 WL 113390, at *4 (D. Md. Jan. 12, 2012) (dismissing promissory estoppel claim where plaintiff's allegations where the "detriment of which [plaintiff] complains [] was not avoidable ***only*** by the enforcement of the promise") (emphasis in original).

In fact, the ASCs' allegations foreclose this outcome by contending that the "Cigna-insured patients remain responsible for the full amount of the ASCs' charges if Cigna does not pay their claims." (CC ¶ 40.) In other words, the ASCs admit that even if Cigna refused to reimburse them for their services, the ASCs could still pursue their patients for any unpaid bills. The truth of the matter is that the ASCs not only refuse to collect these outstanding amounts by telling their patients that they are under no obligation to pay the amounts, but their business model depends on them not making collections. (Compl. ¶¶ 122-26.) For the purposes of this motion, however, it is enough that the ASCs do not allege that they ever attempted to collect any unpaid amounts from their patients. The ASCs are therefore precluded from claiming that enforcement of Cigna's alleged coverage promises is their "only" remedy.

For the same reason, the ASCs cannot show that any "injustice" would result if Cigna's alleged promises is not enforced, another critical element of promissory estoppel. *See Union Trust Co. of Md. v. Charter Med. Corp.*, 663 F. Supp. 175, 179 (D. Md. 1986) (dismissing promissory estoppel claim where no injustice would result if alleged promise were not enforced), *judgment aff'd*, 823 F.2d 548 (4th Cir. 1987); *Pavel Enters., Inc. v. A.S. Johnson Co., Inc.*, 342 Md. 143, 168-69, 674 A.2d 521, 533-34 (1996) (affirming trial court's dismissal of promissory estoppel claim where plaintiff did not establish that binding defendant was necessary to prevent injustice). In fact, not only do the ASCs admit that they have an untapped right to collect on the patients' unpaid bills, their counterclaim makes clear that their patients have recourse against

Cigna through appeals of Cigna's benefit determinations and, if their appeals are unsuccessful, claims for benefits under ERISA or common-law breach of contract. (CC ¶¶ 51-53.) The ASCs may not want to follow plan procedures, but their patients' ability to do so shows that no injustice would result if the Court dismissed their promissory estoppel claim, which is reason alone to grant Cigna's motion on this count.

CONCLUSION

For the reasons stated above, Cigna moves to dismiss the ASCs' Counterclaim in its entirety.

DATED this 5th day of December, 2014.

Respectfully Submitted,

By: */s/ Stuart A. Berman*

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CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of December, 2014, I filed and served the foregoing MEMORANDUM OF LAW IN SUPPORT OF CIGNA'S MOTION TO DISMISS THE ASCS' COUNTERCLAIMS via CM-ECF which will send the notification of such filing to all counsel of record.

/s/ *Stuart A. Berman*